Bureau of TennCare

Policy Manual

Policy No: BEN 07-001	
Subject: Hospice	
Approval:	Date: March 15, 2007

PURPOSE OF POLICY STATEMENT:

The purpose of this policy is to provide an explanation of the hospice benefit that is covered under TennCare and to identify the specific obligations of the managed care organizations (MCOs) regarding payment for hospice and hospice-related care. This policy statement supersedes TSOPs 013 and 013A.

DISCUSSION:

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A participating hospice meets the Medicare conditions of participation for hospices[1] and has a valid provider agreement with a participating MCO. In order to be eligible to elect hospice care, an individual must be certified by a physician as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six (6) months or less, if the illness runs its normal course.[2]

The hospice benefit under TennCare is almost identical to that provided to Medicare beneficiaries under Medicare Part A. Under either program, once an individual elects the hospice benefit, that individual has chosen to end curative treatment for his or her terminal illness. TennCare will not pay for curative services, including drugs, relating to the treatment of the individual's terminal illness. TennCare will continue to pay for other services for illnesses not related to the terminal illness. See the example under the section below entitled "Coverage of services outside the hospice benefit."

TennCare follows the same hospice benefit period used by Medicare. The election periods are:

[1] TennCare Rules 1200-13-13-.08(9)
[2] The Social Security Act §1905(o)(1)(A)

- An initial 90-day period
- A subsequent 90-day period
- An unlimited number of 60-day periods.[3]

TennCare also follows the same certification procedures and election procedures, as well as statements of election, revocation, and change of hospices as used by Medicare. TennCare enrollees must obtain hospice services from hospices that are providers in their MCOs.

A dual-eligible individual, meaning one who has both Medicare and full TennCare Medicaid benefits, who elects hospice coverage under TennCare, must also request hospice services from the Medicare program. If a dual eligible wishes to revoke the hospice benefit he/she must revoke both the Medicare and the TennCare hospice benefit. He/she cannot have one and not the other.[4]

POLICY:

Hospice is an optional benefit under the Medicaid program.[5] It is a covered benefit for adults and children under both TennCare Medicaid and TennCare Standard. Hospice services are covered by the MCOs.[6]

Choice of hospices. A TennCare enrollee must select a hospice that meets the Medicare conditions for participation for hospices and has a valid provider agreement with the MCO.[7] As with most provider types, the enrollee's choice of providers is limited to those hospice providers that participate in the enrollee's MCO.

A dual eligible may select a Medicare participating hospice agency for services even if that agency does not participate in the enrollee's MCO, since Medicare, and not TennCare, is the primary payer.

Covered hospice services. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the category of service.[8] Core hospice services (identified by "*") must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads or to obtain physician specialty services.[9] Definitions for these services are found at 42 CFR 418.200.

- Nursing services*
- Medical social services*
- Physician services*
- Counseling services*

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[3] The Social Security Act §1802(d)(1)
[4] CMS *State Medicaid Manual* §4305.3; CMS *Medicare Benefit Policy Manual* Chapter 9 §20.3
[5] 42 CFR §440.225
[6] TennCare – MCO Contractor Risk Agreement § 2-3.a.1(b)
[7] The Social Security Act §1905(o)(1)(A)
[8] 42 CFR 418.202
[9] 42 CFR 418 Subparts D and F

- Physical therapy, occupational therapy, and speech-language pathology
- Home health aide and homemaker services
- Medical appliances and supplies, including drugs and biologicals
- Short-term inpatient care (including short-term inpatient care as a means of providing respite for the individual's family or other persons caring for the individual at home)

Room and board. For purposes of the TennCare hospice benefit, a nursing facility may be considered the residence of an enrollee.[10] An enrollee living in such a setting may elect the hospice benefit. When he does, his room and board expenses in the nursing facility thus become a part of the hospice benefit and are no longer covered under the TennCare nursing facility program.[11]

Therefore, the nursing facility room and board arrangements are covered by the MCOs as a part of the hospice benefit. An addition to hospice reimbursement is made in this situation to take into account the room and board provided by the facility. The MCO must pay the hospice at least 95% of the nursing facility's per diem, as established by the Comptroller's Office for the Bureau of TennCare, for the enrollee's room and board. The hospice must, in turn, reimburse the nursing facility at least 95% of the nursing facility's per diem for the enrollee's room and board.[12]

For individuals dually eligible for Medicare and TennCare Medicaid, Medicare makes the full payment for hospice services, except for room and board charges in nursing facilities. Individuals who are dually eligible for Medicare and TennCare Medicaid will have their room and board care in the nursing facility paid for by the MCO, since for dually-eligible persons the MCO is responsible for TennCare-covered services not covered by Medicare. Because room and board is not covered by Medicare, it cannot be treated as a "cross-over" item for partial payment by TennCare.

TennCare does not pay for room and board services in a residential hospice. The Social Security Act provides for payment only to be made to nursing facilities.[13]

Coverage of drugs for hospice patients. As in Medicare, only drugs as defined in section 1861(t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the patient's terminal illness are covered under the TennCare hospice benefit.[14] There are times when TennCare hospice patients may require TennCare-covered drugs for treatment of diagnoses unrelated to their terminal illness. When that happens, they will get their drugs through the regular TennCare pharmacy program outside of the hospice benefit. Drugs covered by the TennCare pharmacy program are provided in accordance with TennCare rules 1200-13-13-.04(1)(b)(26) and 1200-13-14-.04(1)(b)(26). Hospice patients who are children under the age of 21 and hospice patients who are adults living in

[10] The Social Security Act §1905(o)(1)(A)
[11] The Social Security Act §1905(o)(B)(3); TennCare – MCO Contractor Risk Agreement §2-3.f
[12] TennCare MCO Contractor Risk Agreement §2-3.a.1(b)
[13] The Social Security Act §1905(o)(1)(A)
[14] 42 CFR §418.202(f)

Nursing Facilities have no quantity limits on the number of prescriptions per month covered by the TennCare pharmacy program.

Coverage of related services. The Medicare hospice benefit states that any service that is specified in the patient's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may be made by Medicare is a covered hospice service. The TennCare hospice benefit is the same; however such services in the patient's plan of care must be a TennCare-covered service.[15]

Coverage of services outside the hospice benefit. TennCare-covered services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the individual when medically necessary.

Example: Mr. Brown is a dual eligible with terminal cancer and has elected hospice care. He must waive his rights to direct payment from Medicare or TennCare for services related to his terminal illness because these services are being provided under the hospice benefit. Mr. Brown also has insulin-dependent diabetes. Services provided that are related to his diabetes would be covered outside the hospice benefit as these are not directly related to the reason he is receiving hospice services.

Special coverage requirements.

Covered under this requirement:[16]

- **Periods of crisis:** a period in which a patient requires continuous care which is primary nursing (RN or LPN) care to achieve palliation or management of acute medical symptoms.
- **Respite care:** short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home.
- **Bereavement counseling:** consists of counseling services provided to the individual's family for a period of one year after the individual's death. It is not separately reimbursable.
- **Special modalities:** A hospice may use chemotherapy, radiation therapy, and other modalities for *palliative purposes* if it determines that these services are needed. The use of such modalities is not for curative purposes, but for the relief and control of pain or symptom management. No additional payment is made regardless of the cost of these services.

Copays. Hospice patients are exempt from copays under the TennCare Program.[17]

Hospice payment rates to be used by MCOs. TennCare payment for hospice care must be made at least as much as one of four Medicare rates for each day in which an individual is under the care of the hospice.

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[15] Dear State Medicaid Director Letter, dated August 13, 1998
[16] CMS *State Medicaid Manual* §4305.6
[17] CMS *State Medicaid Manual* §4306.3; TennCare Rules 1200-13-13-.05 & 1200-13-14-.05

There are four (4) levels of care into which each day of care is classified. Definitions for these levels of care are found at 42 CFR 418.302.

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

The basic daily payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to hospice services provided to the patient, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group. These activities include the establishment of the plan of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies.[18]

If a physician is an employee of the hospice, or providing services under arrangements with the hospice, an additional payment is to be made to the hospice for other physicians' services such as direct patient care.[19]

The hospice agency is to notify the MCO when the physician who has been designated as the attending physician is not a hospice employee. Such independent attending physicians are to be reimbursed according to the MCO's reimbursement methodology.[20]

DEFINITIONS:

Change of hospices: A change of hospices occurs when an individual wishes to change the hospice from which services are being received. An individual may change hospices once per election period.

Election periods: The periods for which a TennCare enrollee who has a terminal illness may elect to have hospice services provided in lieu of curative care.

Room and board [for services provided in a nursing facility]: includes the performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the enrollee's room, and supervision and assisting in the use of DME and prescribed therapies.

Statement of election: The process whereby an individual submits documentation to a particular hospice of his/her desire to receive hospice services.

Statement of revocation: The documentation a patient submits to the hospice when he/she no longer desires hospices services.

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[18] CMS *State Medicaid Manual* §4307
[19] Ibid.
[20] Ibid.

Terminal illness: An illness that, if it runs its normal course, has a medical prognosis of six (6) months or less to live.

OFFICES OF PRIMARY RESPONSIBILITY:
TennCare Office of Networks
TennCare Office of Contracts Development and Performance
TennCare Office of Medical Director

REFERENCES:
The Social Security Act §1814(a)(7); §1861(dd)
42 CFR Part 418
CMS *Medicare Benefit Policy Manual* Chapter 9
CMS *State Medicaid Manual* §4305
Federal Register 70 FR 70532; November 22, 2005
Dear State Medicaid Director Letter, dated August 13, 1998
TennCare – MCO Contractor Risk Agreement
TennCare Medicaid Rules and Regulations 1200-13-13-.04
TennCare Standard Rules and Regulations 1200-13-14-.04